SECTION I: to be completed	by hospital						
Name of Hospital	Street Address		City or County		State	ZIP Code	
B1		B2		В3	B4		B5
Hospital Provider Number	Total Number of Beds		Total Number of Certified Bo	eds	Other Data — Does the hos	☐ Yes ☐ No	
For the past year: A. Total number of	of admissions to cortified areas	B7		B8	Range of Patients		B9
	h) (year)	_		B10	range of Fallents		B11
C. Medicare/Medicaid Billings				D. Oth		operate a separate MEDICAID ONLY-Residential m for Psychiatric patients under the age of 22?	
MEDICARE/Part A	Billed		Collected			□ Yes □ No	
MEDICARE/Part B MEDICAID							
40.0							B12
13. Current Hospital Statistics (on day)							
	Name of Ward			В	ed Capacity	Patient Census	

Name of Ward	Bed Capacity	Patient Census
		Total Patient Census

MEDICARE/MEDICAID PSYCHIATRIC HOSPITAL SURVEY DATA (contd)										
SECTION II: to be completed by the survey team										
Dates of Survey (beginning)	Dates of Survey (ending date)	Type of Survey:	☐ Initial (B16)	☐ Recertification (B17)	☐ Follow-up (B18)					
///(year)	(mm) (day) (year)		☐ Complaint (B19)	☐ Second Follow-up (B20)	☐ Concurrent with General Hospital (B21)					
Survey Team Composition		Total Number of Surveyors on Site								
☐ Administrator	(B22)	□SA	(B32)							
☐ Nurse	(B23)	□RO	(B33)							
□ Dietician	(B24)	☐ Consultar	<b>it</b> (B34)							
☐ Pharmacist	(B25)	□СО	(B35)							
☐ Social Worker	(B26)									
<ul><li>LSC Specialist</li></ul>	(B27)									
☐ Sanitarian	(B28)									
☐ Physician	(B29)									
☐ Psychologist	(B30)	Total Number	of Surveyors on Site	(B36)						
☐ Other	(B31)									
19. Certification of Findings		1								
I certify that I have reviewed the Facility was found to be	d each Condition of Participation in compliance with the Condition	and Related S ons and/or Stan	tandards for Psych dards.	niatric Hospitals, and unless	indicated on the CMS-2567,					
Signature			Title		Date					
Signature			Title		Date					
Signature			Title		Date					
Signature			Title		Date					

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0378. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

Form CMS-724 (9-94)